Compared Security Design S	Please send this form with the		. You must Type or Pr service provider at the		
All STORM \$43 All STORM \$43 All STORM \$43 All STORM \$45 All ST			ICS		
Allace (Last, Risk) Date of Birth, immiddity)	e Name & Number: Patie	ent Name: (Last, First,)		Date: (mm/dd/yy)	
ABAST. (Bast, Risk) Date of Birth: Immodelly) SIGN FAR A SIGN F	taton 843				
334 557-1568	1 3	iount aun	Jonu !		
Introduct Internation Introduct Internation Intern	te Phone # Alia	s: (Last, First,)	1	Date of Birth: (mm/dd/yy)	
Introduct Internation Introduct Internation Intern	34) 567,4548		1	50,06,80	Z
Section Sect					\geq
Signature Sign	ite Fax # Inn	nate#		PHS Custody Date: (mm/dd/yy)	- → `
Will liver be a charge? Sax Sa	334) 567-1538	1001-	5/6	11115188	ರಾ
Sex					뀰
Propose Prop				Potential Release Date: (minudaly)	-2 -
Peoponsible party: Pio Pio Peoponsible party: Pio	۱۱۶	<u> 1 18 -9 8 - 7</u>	126	071 011	i
Recuesting Provides: Deep No.	ELIZE TO HO COMPANIE TO LAMBIE				
Results for a complaint directed physical examination: Support Consultation		Health Ins.(Excludes Medicare/M	edicaid Managed Care altern	ative plans)	
Requesting Provides: Physician Proposition Proposition Proposition Provided Proposition	Auto Ins.	Other, be specific (Evoluties Med	icare, Medicaid and Veterans	: Administration Services):	
History of filness/finanty/symmtoms with Date of Oncest:		CLINICAL	DATA		
Eachity Medical Director Signature and Date: Cost Sye Econn 12/2014	Requesting Provider	□ NP, PA □ Dental			
Eaclifity Nicetical Diseason Signatures and Date: Do 20/3-5	1111	. [History of illness/injur	y/sypmtoms with Date of Onset:	
Sopkements chock for "approved by protocol"	1 - 4 been the			$\epsilon = \frac{1}{2}n$	1
Sopkements chock for "approved by protocol"	Facility Medical Director Signature and Date:		Last Exo	LExam 12/22/04	1
September substate for "approver we protocol"	1 1 1 1	1	~ ~ ~ ~		
Place a check mark (**) in the Service Type requested (one only) and complete additional applicable fields. Common vist (ov)	1 (A A Trains		00,90	(3-2) ··	
Place a check mark (**) in the Service Type requested (one only) and complete additional applicable fields. Compared additional applicable fields.	The second service for "second we protect		-6-		
Complete additional applicable fields. Complete Surgery (OS)		·	05 24	0120	
Compress Surgery (OS)			$\triangle u \otimes$	0/25	
Comparisont Surgery (OS) Colarysis (DA)			<u> </u>	l de la constitución de la const	
Estimated Date of Service (mm/dd/yy) [This starts the approval window for the "open authorization period"] Mutitiple Visita/Treatments:	Stoffice Visit (OV)	Scheduled Admission (SA)	Results of a complai	nt directed physical examination:	
Estimated Date of Service (mm/dd/yy) (This starts the approval window for the "open authorization period") Muttiple Visita/T readments:	Outpatient Surgery (OS) Dialysis (OA)	,	1	•	
Estimated Date of Service (mm/dd/yy) (This starts the approval window for the "open authorization period") Muttiple Visita/T readments:	Routine	Urgent	· ·		
This starts the approval window for the "open authorization period"			1		
Multiple Visits/Treatments: Radiation therapy Chemotherapy	Estimated Date of Service (mm/dd/yy)				
Muttiple Visits/Treatments: Radiation therapy Chemotherapy Number of Visits/Treatments: Other Specialist referred to: Stadford Type of Consultation, Treatment, Procedure or Surgery: The house of Each Diagnostis: ICD-9 code: You must include copies of perflinent reports such as lab results, x- ray interpretations and specialty consult reports with this form.	This starts the approval window for the For	en withodization period?	i		
Number of Visits/Treatments: Chamotherapy					
Number of Visits/Treatments:	I Inches to the inchest of the inches in the				
Specialist referred to: Diagnostis: Type of Consultation, Treatment, Procedure or Surgery: The Normal Cycle Grant Diagnostis: Tob-9 code: You must include copies of pertinent reports such as lab results, x- ray interpretations and specialty consult reports with this form. Pertinent Documents have been stached and fixed. UM DETERMINATION; Afternative Treatment Plan (explain here): More Information Requested information. Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.	D K			•	
Type of Consultation, Treatment, Procedure or Surgery: The Consultation, Treatment from patient or possible follow-up appointments or possible follow-up appoint		0418	Provious transment	t and seconds (including medications):	
Type of Consultation, Treatment, Procedure or Surgery: The North All Consultation, Treatment, Procedure or Surgery: The North All Consultations and All Consultations and Specialty consult reports with this form. Pertinent Documents have been attached and fexed. UM DETERMINATION; Alternative Treatment Plan (explain hore): Afternative Treatment Plan (explain hore): More Information Requested: (See Attached) Date resubmitted: Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.	Specialist referred to:	10.1	LICARORE GENTHERS	f stiff teshottse fittorgania memerani-t-	
Diagnosis; ICD-9 code: You must include copies of pertinent reports such as tab results, x- ray interpretations and specialty consult reports with this form. Pertinent Documents have been attached and feed. UM DETERMINATION; Atternative Treatment Plan (explain hore): Atternative Treatment Plan (explain hore): More Information Requested: (See Attached) Date resubmitted: Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.		->			
Diagnoxis; ICD-9 code: You must include copies of pertinent reports such as tab results, x-ray interpretations and specialty consult reports with this form. Pertinent Documents have been attached and fexed. Possible follow-up appointments** UM DETERMINATION; Offsite Service Recommended and Authorized Alternative Treatment Plan (explain here): Dix nut & Y. Hy Mare Information Requested: (See Attached) Date resultmilled: Resultantive with requested information. Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.	Type of consultation, freatment, Procedur	te or surgery;	1		
Diagnoxis; ICD-9 code: You must include copies of pertinent reports such as tab results, x-ray interpretations and specialty consult reports with this form. Pertinent Documents have been attached and fexed. Possible follow-up appointments** UM DETERMINATION; Offsite Service Recommended and Authorized Alternative Treatment Plan (explain here): Dix nut & Y. Hy Mare Information Requested: (See Attached) Date resultmilled: Resultantive with requested information. Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.	11	=			
Diagnoxis; ICD-9 code: You must include copies of pertinent reports such as tab results, x-ray interpretations and specialty consult reports with this form. Pertinent Documents have been attached and fexed. Possible follow-up appointments** UM DETERMINATION; Offsite Service Recommended and Authorized Atternative Treatment Plan (explain here): Dix nut & Y. Hy. More Information Requested: (See Attached) Date resultmilled: Resultant Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.	I to vone the	~~ · ·	1		
ICD-9 code: You must include copies of pertinent reports such as lab results, x- ray interpretations and specialty consult reports with this form. Pertinent Documents have been attached and fexed. UM DETERMINATION; Afternative Treatment Plan (explain hore): Mare Information Requested: (See Attached) Date resultmilled; Resultmitted with requested Information. Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.					
You must include copies of pertinent reports such as tab results, x- ray interpretations and specialty consult reports with this form. Pertinent Documents have been attached and fixed. possible follow-up appointments** UM DETERMINATION;				•	
ray interpretations and specialty consult reports with this form. Pertinent Documents have been attached and fixed. Possible follow-up appointments** UM DETERMINATION;		ute such so tah resulte			
Pertinent Documents have been attached and fored. UM DETERMINATION;			***For secui	rity and safety, please do not inform:	patient o
UM DETERMINATION; Offsite Service Recommended and Authorized Afternative Treatment Plan (explain hore): Dire met. Much S. Liv. More Information Requested: (See Attached) Date resubmitted; Resubmitted with requested information. Date resubmitted; Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.		•] }	possible follow-up appointments**	
Afternative Treatment Plan (explain hore): More Information Requested: (See Attached) Date resubmitted:			1		
Mare Information Requested: (See Attached) Date resultantified:	UM DETERMINATION;	Offsite Service Recommende	d and Authorized		
☐ Mare Information Requested: (See Attached) ☐ Resubnitted with requested Information. Regional Medical Director Signature, printed name and date required: ☐ Do not write below this line. For Case Manager and Corporate Data Entry ONLY.	Afternative Treatment Plan (explain hore):	10 L	- P	5/1.	
Date resubmitted: Resubmitted with requested information.	11_	1122 mg	. our	Y. W.	
Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.	☐ More Information Requested: (See Attached)	l			
Regional Medical Director Signature, printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ORLY.	k ! _	Date resubmitted;		, as 1	
printed name and date required: Do not write below this line. For Case Manager and Corporate Data Entry ONLY.			- Andrewson and the second		
Do not write below this line. For Case Manager and Corporate Data Entry ONLY.		/ 4)	A CONTRACTOR OF THE PARTY OF TH	1/ 5	بلد
	printed name and date required:	$1 \sim 0$	P. Carlotte	し ラー	0 1
Cert Type; Med Class; OFT code; UR Auth #:	Do	not write below this line. For Cr	se Manager and Corpo	rate Data Entry ONLY.	
	Cert Type; Med Class;	CFT code;	***	UR Auth #:	
	N 1	1 1		1 1	